HealthLeaders InterStudy
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10 HEALTH PLAN ANALYSIS
ARTICLE PULL-OUT

Content from HealthLeaders-InterStudy's
New England Health Plan Analysis, Spring 2010, Vol. 9, No. 2:

April 26, 2010

R.I. Expands All-Payor Chronic Care Medical Home Pilot

Rhode Island has expanded its all-payor chronic-care medical home initiative, which now encompasses just more than 50,000 patients and focuses on diabetes, coronary artery disease and depression. All of the state's major insurers—Blue Cross & Blue Shield of Rhode Island, UnitedHealthcare of New England and Neighborhood Health Plan—are involved in the project, along with the state's Medicaid program. Dubbed the Chronic Care Sustainability Initiative, the pilot launched in 2008 with five sites, 26 providers and 26,000 covered lives.

Though a complete evaluation is still ongoing, preliminary statistics show an increase in screening levels and follow-ups. For example, reports show the number of diabetic patients with appropriate checks of their hemoglobin A1c level rose from 72 percent to 83 percent. The percentage with good control of their cholesterol, with an A1c level of less than 7, has risen from less than 35 percent to 42 percent. Health plans are providing funding to allow nurse case managers to operate on site, as well as a monthly $3 per-member, per-month fee to each practice for enhanced services (around $125,000-$300,000 per year for each, depending on practice size).

Table 5-1: Rhode Island Chronic Care Patient-Centered Medical Home At A Glance

Pilot sites	Includes 52 providers, 54,000 covered patients
Extra payment	Sites are paid enhanced care management fee of $3 per member, per month
New revenue	New revenue to practices ranges from $125,000 to $300,000 per year, depending on practice size
Conditions targeted	Diabetes, coronary artery disease, depression
NCQA targets	As of July 1, 2009, all pilot sites had achieved Level 1 recognition as PCMH
EHR use	Pilot sites are using electronic medical records or chronic disease registries to collect and monitor clinical quality throughout the pilot

Source: Office of the Health Insurance Commissioner

"Based on data and reports from practices, we see the model in Rhode Island as very promising," said Meredith B. Rosenthal, associate professor at the Harvard School of Public Health. Harvard is evaluating the practices' transformation into primary-care medical homes, as well as determining the return on investment. The evaluation of cost and quality data and hospitalization rates, for instance, is ongoing and will be a key

barometer. "What is promising is that the [pilot] practices have all put significant structure and resources into place, and our information shows the care managers have really been important for these practices."

Existing contracts expire in September 2010, but are likely to be renewed and expanded in the second quarter of 2010. Nine new sites have come online, with around 26,000 patients. One cluster is around South County Hospital in Wakefield. "One thing we wanted to do was understand and build relationships between the medical home and the hospital to which they refer," said Rhode Island Health Insurance Commissioner Christopher Koller. The initiative is being supported by Koller's office and was created with seed funding from the Center for Health Care Strategies.

Pharma Can See Benefits From PCMH Concept

Pharmaceutical manufacturers might see a PCMH-designated practice as a double-edged sword. As doctors gain better monitoring tools, patient registries and more time to converse with patients about managing their conditions, the drug market becomes a zero-sum game—more effective drugs will win and comparatively less effective ones will lose. But that's balanced against the behavior of better-educated and more compliant patients. The Patient Centered Primary Care Collaborative has become a national clearinghouse in support of practice transformation, and among its leading supporters are Pfizer, Merck and other drug companies.

"This approach will be good for the pharmaceutical business, as pharmacy costs in this kind of practice environment usually do go up as compliance is enhanced," said Thomas Bledsoe, M.D., a primary care internist with pilot site University Medicine, Providence, as well as a professor of medicine at Brown University. "These patients are on a lot of meds. In our [medical home pilot] practice we are looking at bringing in a pharmacist, free to the patient, so they can be better educated and have more time understanding the drug regimen. If they are educated and taking the drugs in the appropriate way, there is potentially a big trade-off on the other end."

The medical home concept has caught on among providers, patients, insurers and states eager to try something new in the battle against rising costs, and New England has followed the trend, with programs under way in Massachusetts, Vermont, Maine and New Hampshire. The initial sites in Rhode Island's chronic care initiative are Coastal Medical, Family Health & Sports Medicine Foundation, Hillside Avenue Family and Community Medicine, Thundermist Health Center and University Medicine Foundation.

The PCMH model is a team-based model of care, whereby a primary-care physician coordinates care throughout a patient's lifetime. This care includes preventive services and coordinated treatment of acute and chronic illnesses. Because of the emphasis on outcomes, medical homes are designed to improve health through better compliance with treatment regimens, particularly for chronic disease.

Table 5-2: Principal Characteristics Of A Patient-Centered Medical Home

» **Personal physician** – each person has a personal physician trained to provide continuous and comprehensive care.
» **Physician-directed practice** – physician leads a team at the practice level who are collectively responsible for ongoing care of patients.
» **Coordinated care** – care is coordinated through all elements of the healthcare system.
» **Quality and safety** – use of evidence-based medicine, ongoing education
» **Full value payment** – payment recognizes the added value to patients who have a PCMH.
» **Use of health information technology (e-prescribing, patient registry)** – includes open scheduling, expanded hours and new options for communication between physicians and patients.
» **Care for whole person** – physician takes responsibility for arranging care with other professionals.

Sources: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Ostopathic Association

"Through the pilot, we have been able to add a quality assistant that does data management and helps with population management. They can run a list of all patients with diabetes, for example, seeing who has the highest numbers, when they were here, etc.," Bledsoe said. "The practice can reach out rather than wait for the patient to come back. There is great personal satisfaction knowing that after I see a patient, I have assurances several other members of my team will be working with them. We are starting to get some real data that patients are improving. They come back, their numbers are better, they feel better, they say they know more about their problem and how to manage it."

Pilot sites are leveraging the technology they have already adopted and the resources that insurers have made available, such as the care manager. "Our pilot sites report the care manager is one of the big differences," Koller said. "Now you have someone on site who can focus on the sickest patients, follow up with them between visits and develop relationships."

All pilot sites use a registry or electronic health record with decision support, and payors generally work with individual practices to develop alternative payment for primary care that supports the infrastructure and system investments needed to deliver care, as well as rewards for high-quality and efficient treatment. The most common payment method is a three-tiered system that includes a care management fee, ongoing fee-for-service payments, and a performance-based bonus payment.

"One of the tests is whether the funding is enough to motivate change in practices," Bledsoe said. "All five here have changed significantly in the last 18 months, and you could say we are the early adopters. Everyone recognizes you have to show it is cost-effective to keep the buy-in, but we have every reason to expect the pilot will continue on [past its original end date of September 2010]."

Results Beginning To Roll In

Results are starting to roll in from some medical home pilots already under way nationwide. For instance, the first year of Pennsylvania's sweeping PCMH initiative is showing measurable improvements in the health of diabetics, providing the momentum for expansion of the program statewide to cover more chronic illnesses.

Since the state started tracking the first set of patients in the Philadelphia market in July 2009, the program has achieved improvements in several key metrics for diabetic care, including a 71 percent increase in the number of diabetics getting eye exams and a 142 percent increase in those getting annual foot exams. The number of patients lowering their cholesterol below 130 rose by 43 percent, and those getting their blood pressure below 140/90 increased by 25 percent.

Blue Cross Blue Shield of Michigan has promising data as well. Comparing claims by practice, the designated PCMH practices have hospitalization rates 20 percent lower than non-designated ones for patients with chronic conditions that are sensitive to ambulatory care. Designated practices have also demonstrated a 12 percent lower rate of need for radiological imaging, and a rate of patient emergency-room visits that is 4 percent lower than other practices. When considering ER visits for conditions such as flu and viral syndrome, as opposed to broken arms and traffic crashes, designated practices have a 9 percent lower visit rate.

Outlook

Expect more attention to be paid to efficiency, with physicians looking for the cheapest, most effective medications and care managers flagging duplicative tests and services in medical homes. The concept is certainly taking off nationwide, and the movement's focus on large medical practices is wise, but the real challenge will be how to integrate the concept into smaller physicians' offices.